Professional autonomy

Is it the future of general practice?

John Fraser
FRACGP, FAFPHM, FACM, is Associate Professor and Director, New England Area Rural Training Unit, New South Wales.
john.fraser@hnehealth.nsw.gov.au

Internationally, rising financial costs and increasing expectations of health care delivery have increased regulation and decreased the autonomy of general practitioners and other health care professionals. This article explores professional autonomy within Australian general practice, and outlines the importance of autonomy in systems approaches to organisational change in general practice.

Australian general practice overlaps between meeting the needs of individuals and communities; it combines individual patient care with an increasing population health and public health role.[1,2] General practitioners conduct this work within a complex medical system.[3] Systems theory predicts that small changes to this environment or the behaviour of key stakeholders can have strong effects on the role of general practitioners.[3,4]

In a 2004 issue of the *Medical Journal of Australia*, key stakeholders in general practice were asked to comment on the plight of a fictitious undervalued, disempowered GP working in the year 2020, Dr Zen. She was presented as a possible future vision of general practice based on an analysis of factors which impact upon general practice at present.[5] Regulation had reduced Dr Zen's role to pushing buttons to answer questions in an evidence based computerised diagnostic pathway. Tired, she could spend only 5 minutes with a patient. Longer consultations were punished by pay reductions. She aspired to become a taxi driver, which would provide her with the 'opportunity to talk to customers'.[5]

Coote's critique of Dr Zen's situation identified that professional autonomy was central to general practice's future, and all of the identified challenges Dr Zen faced were linked to autonomy in some way. Autonomy is central to the status of a profession and needs to be preserved to prevent this dread scenario from eventuating.[6]

Australian general practice autonomy

Gregory and Chew[5] identified no less than 26 driving forces that restricted the fictional Dr Zen. These were classified into factors related to the GP, the patient, and society. The list was not exhaustive and, in reality, many of these factors interrelate. Australian GPs also identify the influence of interprofessional relationships (ie. between GPs and nonmedical health professionals) and intraprofessional relationships (ie. between GPs and other specialists) as important to the health care system. These relationships can occur at a micro (individual) level or at a macro (organisational) level.[7,8]

Autonomy is subdivided into clinical, economic and social constructs by practising Australian GPs.[7,8] They consider organisations representing the interests of patients, funders of health services, and governments as important influences upon their changing role in this system.[7,8]

A tension exists between the desire to maintain GP independence and autonomy, and a desire to adopt newer roles (eg. working within a multidisciplinary team or developing a broader public health role). These newer models of care could provide greater diversity of employment and improved job satisfaction for GPs.[7,8] Internationally, rising costs and increasing consumer and government expectations to monitor quality, contain costs, and integrate health services have increased regulation and reduced the autonomy of GPs and other health care professionals.[9–11] This can reduce GPs' job satisfaction, their perceived value, and make recruitment to and retention of the general practice workforce more difficult.[7,8]

Sociology, profession and autonomy defined

Sociology is a useful tool to analyse autonomy in medicine.[12] Sociologists analyse how the interaction of class, gender, professional interests, power and ethnicity influence medical knowledge, its organisational structure and changes to its practice. In a sociological sense,

medical knowledge is not purely scientific, but shaped by the society (or system) in which medicine is practised.[12] A profession is an 'educational group with a recognised or sanctioned monopoly of a defined part of the labour market. Access is based on specialised knowledge'.[10] Professionals exert autonomy over access and use of this knowledge in clinical, social and economic aspects of their defined work.

Australian GPs view autonomy and control and the possession of special skills as central to their professional identity.[7,8] There is increasing recognition that general practice has a body of specialised knowledge, characterised by community service, research and teaching.[13] The Royal Australian College of General Practitioners defines the discipline[2] and acknowledges its scope by defining domains in its curriculum.[1]

Australian GPs identify a tension between financial accountability (often imposed by regulators and funders of health services) and clinical decision making (to best meet patient needs) as being 'polar opposites'.[7,8] That 'GPs should be left to organise their own lives' is a commonly held viewpoint.[7,8] The reality of this situation is that GPs are socially embedded in a system, and changes to their autonomy affects the rights and obligations of others.

Ethically, for individuals to be autonomous their 'actions should not be subjected to controlling constraints of others'.[14] A balance between duties and rights of all stakeholders is inherent in this definition. In a bioethical sense, there is a need for 'respect of individuals' views and rights so long as their thoughts and actions do not seriously harm other persons'.[14] This balancing of rights and obligations may not always reflect the realities of the present medical care system.

In a discussion of autonomy, Kemp[15] expands on this point: 'Since autonomy for one decision taker is incompatible with control by another, and since all are engaged in the process of adjusting degrees of autonomy and control by another, some conflict is inevitable, regardless of the values being pursued. Only the hermit at one end of the spectrum and the omnipotent at the other can avoid this political process'.

Applying this concept to health care systems, a related term of tribalism has been developed. Hunter[11] argues: 'All developed health care systems operate on the basis of tribalism. That is, they are composed of various tribes, including managers, clinicians, nurses and professionals allied to medicine, all of which are represented by various professional associations. All of these tribes have slightly different goals and perceptions of what constitutes effective care and are pulling in somewhat different directions'.

This influence of tribalism impacts upon GPs' autonomy and would appear to be one of the major barriers to proposed collaborative organisational change in Australian general practice. True collaboration requires agreement from all parties as to their respective functions, a position almost opposite to tribalism.[16] This view is shared by Best, who considers tribalism as being one of the main challenges to (rural) general practice's sustainability.[17] Gregory and Chew[5] found a large number of organisations have some stakeholder involvement in the representation of general practice in Australia. These macro level general practice structures may at times represent differing viewpoints and possess higher levels of autonomy than their individual members.[7,18]

Impacts of unlimited autonomy within the health care system

Is achieving unlimited autonomy necessarily best for Australian GPs or a realistic goal for general practice leadership? Based on systems theory, such a goal could be counterproductive to promoting general practice as a discipline. General practitioners cannot isolate themselves from the rest of the medical system. Health care reforms of the 1990s, which increased linkages between funder, patient and doctor to improve quality and control costs, make redefining the role of the GP as a 'hermit' removed from the rest of the medical system impossible.[10] Furthermore, promoting this isolationist approach limits interaction between GPs and other key stakeholders. This diminishes general practice's potential to negotiate and develop new expanding roles (eg. in enhanced multidisciplinary care or public health).

Systems theory clearly demonstrates that financial and clinical decisions are related.[3,4] Health resources are finite. Clinical, economic or social professional decisions undertaken by a GP (who might be isolated from the best available evidence to optimise health outcomes) incur an opportunity cost for other members of society.[10] A balance is required, however, as excessive standardisation and

Table 1. Sociological questions for Australian general practice

- Does the GP of the future aspire to be protocol driven automaton or, rather, a team leader, managing a health professional team with clinical, health care planning, research, public health and professional development roles?
- What are the views of GPs, patients, and funders on approaches to restructuring the delivery and remuneration of general practice?
- What are the views of GPs, patients, and other health professionals on multidisciplinary teamwork?
- What constitutes an effective health professional team?
- What are the views of GPs, patients, and funders on adapting patient centred approaches to health care delivery?
- What mix of clinical, teaching and research roles will make general practice work more attractive and sustainable?
- How would such changes be advanced and implemented?
- How can a truly public health focus be implemented in general practice?

regulation of general practice can reduce diversity and job satisfaction,[19] create barriers between development and implementation of policy,[19] and reduce GPs' capacity to develop innovative approaches to manage new problems.[4]

Recently, professional organisations have been criticised for protecting the profession, rather than regulating their membership. This criticism has been present in editorials about recent medical news stories such as the Dr Shipman case in the United Kingdom.[20] Individual GPs or medical organisations putting their interests ahead of patients' can engender a lack of trust between medical professionals and patients. This influences health funders, governments and the profession itself to devote more health funding to standardisation, regulation and control, further reducing both the monetary funds available to treat illness and the autonomy of health professionals.[9]

There is some evidence that Australian GPs ignore patients' broader influences on the medical system. In his systems approach research with Australian GPs, Sturmberg[3] found patients were ignored by GPs as a significant influence upon recruitment and retention of workforce. This is surprising, as related constructs of the status of GPs in the health care system and patient centred care were strongly linked by these GPs to workforce issues.

Patient centred care and autonomy

Patient centred medicine in some ways balances the competing interests of funder, patient, and doctor. The GP maintains autonomy through a shared role of clinician and facilitator of patient, input into decision making. This increases trust and job satisfaction and ultimately health outcomes,[21] and reduces the costs of investigations and health expenditure.[22] This model can achieve a balance between autonomy for stakeholders with regulation to manage costs and quality. Further research into general practice systems and sociology is required to explore the feasibility of various models of organisation change in general practice to balance autonomy with regulation.

Future directions

Autonomy is a complex multidimensional construct. General practitioners cannot all be truly autonomous, nor can general practice be all encompassing. General practitioners need to know their limitations in order to optimise care for their patients. The GP of the year 2020 needs to be a leader of a clinical team of health professionals, who is consulted when needed and has clinical, health care planning, research, public health, and professional development roles. A series of questions are raised by this analysis which require further exploration and research to reach an answer (*Table 1*).

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afp CORRESPONDENCE email: afp@racgp.org.au